BAY-ARENAC BEHAVIORAL HEALTH

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
2007 – 1st Quarter

1. **MDCH Specialist: Tison Thomas**
   Report Period: 10/1/06 – 12/31/06
   Program Title: Co-Occurring Disorders: Integrated Dual Disorders Treatment
   PCA#: 20700 Contract #: 20071302 Federal ID: 38-3611656

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The Regional Improving Practice Leadership Team (IPLT) met once in the first quarter of FY 2007. IPLT members reviewed the status of the COD-IDDT implementation project and other Evidence Based Practices (EBP) and emerging practices currently in place across the Affiliation. The IPLT reviewed data on Disability Designation, Employment Status and Criminal Justice Involvement in order to determine if the information would be of value to the group. The group supported further exploration of this data. There was discussion and support for developing a more comprehensive work plan for the IPLT. A draft GANTT chart will be developed for review and possible implementation by the IPLT in the second quarter.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

The Integrated Services Work Group and Advisory Council (ISW/AC) is the primary leadership team for development and implementation of integrated services systems change for the Bay-Arenac PIHP, the affiliated CMHSPs and the Riverhaven Coordinating Agency. In addition to the Bay-Arenac Chairperson/Regional IDDT Coordinator, there is one representative from each

CMHSP: Bay-Arenac Behavioral Health, Huron Behavioral Health (HBH is also a contracted Riverhaven SUD provider), Montcalm Center for Behavioral Health, Shiawassee Community Mental Health and Tuscola Behavioral Health Systems. There is also SUD treatment provider representation from: Bridgewater/Bay Human Services and Kairos Healthcare. A contracted psycho-social rehab agency (Opportunity Center) is also an active member of the Integrated Services Work Group and Advisory Council.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

A consensus document was developed in late 2003. The document was finalized in early 2004 and approved by all members of the AAM Affiliation in 2004. Several contracted CA SUD providers also agreed to the principles and action steps developed in the Consensus Document. The current Consensus Document is dated and it is anticipated that a new agreement will be finalized during the second quarter of this block grant project. Systems priorities such as welcoming, Access screening and data collection are currently in process and have yet to be adopted.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

This is a current underdeveloped area. All current participants are a part of the PIHP/CA delivery system.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

The CO-FIT 100 has been administered twice in the past three years. The initial assessment experienced some administration errors due to a misunderstanding on how to best use the tool. It did not provide information that was found to be of benefit. The second administration of the CO-FIT 100 was completed in June 2006. Each CMHSP partner and participating SUD provider completed the CO-FIT independently. The information was then processed collectively by the ISW/AC to identify systems gaps. With multiple groups completing the CO-FIT, there are issues related to inter-rater reliability, so it was decided the best use of the assessment tool was to use the scores as discussion points for identifying gaps in the system. As the ISW/AC did not meet during the first quarter reporting period it has not been possible to collectively identify and discuss systems gaps. This process will be completed in the second quarter of the Block Grant. In the interim

two clear gaps were identified by the ISW/AC chairperson/Regional IDDT Coordinator and are in the process of being addressed. They are: Under "Welcoming" #3 it is clear that the current consensus document does not emphasize all aspects defined in this category. This document will be revised and reviewed during the second quarter. A second item that was identified and addressed during the first quarter was from "Continuity" #2. Current consumer satisfaction surveys do not address "welcoming attitudes." The surveys were modified during the first quarter to begin gathering consumer satisfaction with "welcoming" during the next scheduled Consumer Satisfaction data collection period.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

Each of the five affiliation partners has completed the COMPASS one time. The results of the tool have been used by each to assist in developing their COD-IDDT work plan and/or quality improvement project. Since Huron Behavioral Health is also a SUD provider, they have also incorporated the COMPASS into their planning efforts for co-occurring SUD services. None of the other participating SUD providers have formally used the COMPASS at this point. It is anticipated that the re-administration of the COMPASS during the 3rd quarter will provide some comparative data that will make the information more useful in developing co-occurring capability.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

The work of the ISW/AC has never been formally chartered as a QI project. The activities and accomplishments of the work group are monitored on a monthly basis by the AAM affiliation partners Operations Council. This group is made up of the Chief Operating Officers (or their designees) of the affiliation. The BABHA Operations Council representative (Chief of Clinical Operations – Gary Lesley) then reports on ISW/AC activities and accomplishments (and any recommendations from the ISW/AC to the Operations Council) to the Chief Executive Officers of the affiliation at their monthly Leadership Council meeting. Feedback from these councils are provided by the Chief of Clinical Operations to the ISW/AC Chairperson/Regional IDDT Coordinator at bi-weekly supervision meetings. The targets and indicators are found in the Regional COD-IDDT Treatment Work Plan. The work plan is consistent with systems efforts to create a Comprehensive, Continuous, Integrated System of Care (CCISC) that will move the system to a combination of co-occurring capable and co-occurring enhanced service delivery models.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

Welcoming, screening and assessment policies and/or procedures are in process with product expected during the 2nd quarter reporting period.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The decision on what teams will implement IDDT will be made by the leadership at each CMHSP partner. Three of the affiliation partners have designated their Assertive Community Team as the IDDT implementation team. The other two are in the process of determining how IDDT will be implemented within their organizations. In regard to how do the IDDT teams "fit" in systems change efforts - it is anticipated that experience of the IDDT implementation teams will provide valuable feedback to the system and service levels as the system moves toward increased co-occurring capability.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

The Fidelity Scale was not used during the 1st quarter reporting period. The scale has been distributed to all affiliation partners for their review. It is anticipated that 1 to 2 Fidelity Assessments will be scheduled during the 2nd Quarter. In terms of other data collection and/or PI activities, the BABH PIHP through AAM Access Center is participating with other PIHP's in a COCE demonstration grant related to access to services. This involves collecting data on co-occurring and non-co-occurring consumers accessing the service delivery system. COD assistance was provided by nationally known presenter Michael Clark, LMSW. Mr. Clark provided introductory MI/SOC trainings for mental health and substance abuse clinicians during this reporting period. The intent was to familiarize all staff with this strength based approach and in particular introduce the Partner IDDT pilot implementation teams to MI/SOC. Trainings were held on 10/10 in Tuscola County, 10/11 in Shiawassee County, 11/6 in Huron County, 11/16 in Bay County and Montcalm County on 12/11.

Also, nationally recognized co-occurring disorder expert Dr. Christie Cline met with Affiliation Medical Directors and leaders on December 1, 2006 to discuss issues related to co-occurring disorders. Specific suggestions were offered by Dr. Cline to assist in COD-IDDT implementation efforts. As a result of the consultation the PIHP has obtained a copy of the ILSA. The positive elements of this assessment process will be considered as the Affiliation develops common clinical forms. Dr. Cline recommended that local psychiatrists begin consulting with each other related to challenging COD cases. This item is on the Medical Staff Meeting agenda for March 2007.

Additional trainings will be held for general staff and IDDT pilot teams in the remainder of the second year of the grant

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

Clinical practice development is still in process. While there has been some limited exposure to system/clinician change issues and the expectation of developing dual competency, a concerted effort in this area has not yet been made. The CODECAT has been administered to Access Center staff, and initial review has been of training needs. It has been decided to hold off on use of the CODECAT results with the Access staff until the COCE Access Project is more complete. It is believed that a more comprehensive training plan can be developed for Access staff by utilizing information from both the CODECAT and the COCE Project. Implementation of the CODECAT with other clinical areas will be addressed during the 4th quarter of the grant. Polices and procedures will need to be developed to help ensure that clinicians will implement competency skills related to co-occurring capability.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

No significant barriers from the state were identified during this reporting period.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there**

areas where you feel that you could use specific technical assistance and/or training in the future?

There were no major barriers encountered that required intervention during this reporting period. As noted elsewhere in this report, technical assistance on Motivational Interviewing/Stages of Change was received from Michael Clark, LMSW via several trainings. No specific TA is being requested at this time.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

The year to date financial statement is attached. No significant implementation/continuation issues occurred during the reporting period.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.**

Second quarter focus will include: 1) To assist affiliation partners in achieving objectives identified from program level COMPASS assessments completed in 2006. 2) Completion and approval for implementation of revised "Consensus Agreement" by Regional Leadership. 3) Develop and finalize initial staff co-occurring competencies for implementation in each CMHSP. 4) Develop improved mechanism for identifying and collecting data on persons with COD. 5) Begin development of self directed training modules for improving staff skills related to treating people with co-occurring disorders. 5) Complete MI-FAST IDDT Fidelity Assessment with BABH IDDT team. 6) Affiliate CMHSPs will complete readiness assessment and propose dates for MI-FAST assessment.

17. **What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?**

Sustainability discussions are ongoing with PIHP Leadership and affiliation partners on strategies to ensure continuation of IDDT efforts after the block grant period ends.

PIHP: Bay-Arenac Behavioral Health
Program Title: Co-Occurring Disorders: Integrated Dual Disorders Treatment
Executive Director: Robert Blackford
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Quarterly Report

Reporting Period	**10/01/06 –12/31/06**
PIHP	Community Mental Health Affiliation of Mid-Michigan
Program Title	Adult Mental Health Services
Executive Director & Address	Robert Sheehan 812 E. Jolly Rd Lansing, MI. 48910
Contact Person	Michael Brashears, Psy.D Director: Adult Mental Health Services 517-346-8372 517-346-8370 (Fax) brashear@ceicmh.org
PDA, Contract #, Federal ID	PDA#: 05B1CMHS-03 Contract#: Federal ID #: 38-6337733

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A	**Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team**	This quarter's activity focused on the development of local trainings related to evidence based practices and COD-IDDT. The Motivational Interviewing and Stages of Change trainings were attended by staff on multiple adult mental health services teams.
B	**System Change process activities related to the integration of Mental Health services and Substance Disorder services and the Impact of this Evidence-Based Practice process on creating system change.**	**Narrative**: The focus this quarter from a system change perspective was to train individuals in Evidence Based Practices that specifically relate to the IDDT model. Our previous structural and systems analysis provided us with information regarding the dearth of staff expertise regarding Motivational Interviewing and Stages of Change. Our Affiliation counties as well as multiple CEI teams participated in this Evidence Based practice training. **Affiliation wide activity included (but not limited to) the following:** 1. **10/2/06 & 10/3/06 Manistee and Newaygo Affiliation** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. Manistee hosted the 2 day training and several staff from the Newaygo ACT team participated in the training.

		Darren Lubbers Ph.D. attended the Manistee/Newaygo training and met with the Affiliation project leaders to review the next steps regarding substance use training for their individual IDDT training needs. 2. **10/20/06** Darren Lubbers Ph.D. met with the CEI Substance Abuse Director (Judi Cates MA) to discuss IDDT substance abuse training and coordination efforts with CEI Adult Mental Health Services and CEI Substance Abuse Services. 3. **10/24/06** Darren Lubbers Ph.D. attended the MDCH COD:IDDT statewide meeting. 4. **10/24/06** Darren Lubbers Ph.D. met with the director of Adult Mental Health Services (Michael Brashears Psy.D.) to review IDDT structural and process progress across systems. 5. **10/25/06** Darren Lubbers Ph.D. met with families from the CEI Evidence Based Practice Family Psycho-education program and presented the IDDT project. Several families and members of NAMI attended this review of the impact of substance abuse and IDDT overview meeting. 6. **10/27/06** Darren Lubbers Ph.D. met with the director of Adult Mental Health services (Michael Brashears Psy.D.) to determine IDDT structural and process progress regarding the future implementation of IDDT services across systems. 7. **10/30/06 & 10/31/06 /9/06** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. CEI conducted the 2 day training at the Holiday Inn South due to the large number of participating staff from multiple Adult Mental Health Services programs. Darren Lubbers Ph.D. and Michael Brashears Psy.D attended the CEI Motivational Interviewing and Stages of Change training and met with the several CEI project

leaders to review the next steps regarding substance use training for their individual IDDT training needs

8. **11/14/06** The CEI Core IDDT administration group met to review the training progress and reviewed structural and process changes required for the continued development of IDDT within CEI and across the Affiliation.

9. **11/14/06** Darren Lubbers Ph.D. met with the CEI IDDT workbook group.

10. **11/27/06 & 11/28/06 Ionia and Gratiot Affiliation** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. Ionia hosted the 2 day training and several staff from the Gratiot team participated in the training. Darren Lubbers Ph.D. attended the Ionia/Gratiot training and met with the Affiliation project leaders to review the next steps regarding substance use training for their individual IDDT training needs.

11. **11/30/06** Darren Lubbers Ph.D. met with Michael Brashears Psy.D. to review CEI and Affiliation training accomplishments and engaged in planning discussion for team level progress. Michael Brashears Psy.D. and Darren Lubbers Ph.D also discussed the format for a newly created CEI and affiliation electronic newsletter that will be distributed quarterly.

12. **12/1/06** Darren Lubbers Ph.D., Rob Davis Ph.D., and Barb Starling MSW met to discuss the format of the training and resource guide for the CEI and Affiliation substance abuse training for Adult Mental Health services staff.

13. **12/4/06 & 12/5/06** Michael Clark MSW conducted a 2 day Advanced Motivational Interviewing and Stages of Change training. CEI hosted the 2 day training and several staff from the Affiliation teams also participated in the training. Darren Lubbers Ph.D.

		attended the training and met with individual project leaders to review the next steps regarding substance use training for their individual IDDT training needs. 14. **12/6/06** Darren Lubbers Ph.D. attended the Ann Arbor IDDT training conducted by Patrick Boyle. 15. **12/12/06** Darren Lubbers Ph.D. attended the IDDT workbook meeting at CEI. 16. **12/15/06** Darren Lubbers Ph.D. attended the MIFAST team meeting in Lansing. 17. **12/19/06** Darren Lubbers Ph.D. attended the MDCH COD:IDDT Statewide meeting.
C	**Milestones and changes**	**Narrative:** This quarter's activity focused on Motivational Interviewing and *Stages of Change training for CEI and Affiliation staff. This Evidence Based* Practice specific training was based on specific structural and process needs assessment that is central to the IDDT model implementation. This quarter also focused on future training and information dissemination needs. In regard to future, next quarter needs, it was determined that we needed to create a specific substance abuse training resource guide and PowerPoint training session. Several staff and team leaders requested training in substance abuse. A team that included CEI substance abuse staff and Adult mental health services staff was created to research the most important

		components of our specific CEI and Affiliation substance abuse training needs. Information dissemination will be accomplished for CEI and our Affiliation sites with an IDDT electronic newsletter. This will enable us to share important National, statewide, CEI and Affiliation research, news and accomplishments regarding the implementation of IDDT. **Affiliation wide and local CMHSP activity included (but was not limited to) the following:** 1. Motivational Interviewing and stages of Change training across 7 counties. 2. The development of an IDDT electronic newsletter. 3. The development of a substance abuse resource guide and presentation series regarding substance abuse as it pertains to an SPMI population. The actual trainings are targeted for early Spring 2007.

D	**Consensus building and collaborative services efforts with otber systems and agencies**	**Narrative:** Consensus building focused on collaboration with MDCH-IDDT state measurements group, MIFAST fidelity team, and local CEI-CMHA and Manistee-Benzie, Gratiot, Newaygo, and Ionia CMH programs **<u>Affiliation wide activity included (but not limited to) the following:</u>** **1. 10/2/06 & 10/3/06 Manistee and Newaygo Affiliation** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. Manistee hosted the 2 day training and several staff from the Newaygo ACT team participated in the training. Darren Lubbers Ph.D. attended the Manistee/Newaygo training and met with the Affiliation project leaders to review the next steps regarding substance use training for their individual IDDT training needs. 2. **10/20/06** Darren Lubbers Ph.D. met with the CEI Substance Abuse Director (Judi Cates MA) to discuss IDDT substance abuse training and coordination efforts with CEI Adult Mental Health Services and CEI Substance Abuse Services. 3. **10/24/06** Darren Lubbers Ph.D. attended the MDCH COD:IDDT statewide meeting. 4. **10/25/06** Darren Lubbers Ph.D. met with families from the CEI Evidence Based Practice Family Psycho-education program and presented the IDDT project. Several families and members of NAMI attended this review of the impact of substance abuse and IDDT overview meeting. 5. **10/30/06 & 10/31/06 /9/06** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. CEI conducted the 2 day training at the Holiday Inn South due to the large number of participating staff from multiple Adult Mental Health Services programs. Darren Lubbers Ph.D. and Michael Brashears Psy.D attended the CEI Motivational Interviewing and Stages of

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E	**Work plan progress:** **(Also see electronic newsletter)**	**See Appendix C**

F	**Staff training and technical assistance** **(Explain how these will be utilized for the program development and improving practices. Please indicate staff coverage for the project with an organizational chart showing the location of the staff for this project.)**	**Narrative: Staff training focused on orientation to Evidence Based Practices and COD-IDDT. Training was developed and provided in all eight CMHAMM counties with over 300 employees in attendance.** **10/2/06 & 10/3/06 Manistee and Newaygo Affiliation** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. Manistee hosted the 2 day training and several staff from the Newaygo ACT team participated in the training. Darren Lubbers Ph.D. attended the Manistee/Newaygo training and met with the Affiliation project leaders to review the next steps regarding substance use training for their individual IDDT training needs. **10/20/06** Darren Lubbers Ph.D. met with the CEI Substance Abuse Director (Judi Cates MA) to discuss IDDT substance abuse training and coordination efforts with CEI Adult Mental Health Services and CEI Substance Abuse Services. **10/30/06 & 10/31/06 /9/06** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. CEI conducted the 2 day training at the Holiday Inn South due to the large number of participating staff from multiple Adult Mental Health Services programs. Darren Lubbers Ph.D. and Michael Brashears Psy.D attended the CEI Motivational Interviewing and Stages of Change training and met with the several CEI project leaders to review the next steps regarding substance use training for their individual IDDT training needs **11/27/06 & 11/28/06 Ionia and Gratiot Affiliation** Michael Clark MSW conducted a 2 day Motivational Interviewing and Stages of Change training. Ionia hosted the 2 day training and several staff from the Gratiot team participated in the training. Darren Lubbers Ph.D. attended the Ionia/Gratiot training and met with the Affiliation project leaders to review

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G	**Barriers and issues encountered (Also include action taken to address them)**	**Narrative:** Barrier identification is still ongoing and at this time continues to focus on clarifying key terms and concepts found in the COD-IDDT fidelity scale. This quarters identified barriers include: 1. The development and training of substance abuse specialist to ensure substance abuse specialists participation in all COD-IDDT team development. **Plan to Resolve Barriers:** Dr. Darren Lubbers in cooperation with the director of CEI substance abuse services (Judi Cates, MA) and Rob Davis Ph.D. and Barb Starling MSW will conduct a substance abuse training series that will include a training resource guide.

H	**COD implementations status (Only for PIHP's at the implementing Stage**	**N/A**
I	**PIHP financial and in-kind support (Is the program having problems with implementation/continuation, should an amendment be initiated?)**	**N/A**
J.	**Describe the activities planned to address the project's goals and objectives for the next quarter.**	**Narrative:** See Appendix C which provides work plan for future activity

Respectfully submitted,

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Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration
Improving Practices Infrastructure Development Grant
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Quarterly Report

Report Period: October 1 – December 31, 2006
PIHP: Kalamazoo CMHSAS dba Southwest Affiliation (KCMHSAS)
Program Title: Integrated Dual Disorder Treatment (IDDT)
Executive Director: Jeff Patton
Address: 3299 Gull Rd., P.O. Box 63 Nazareth, MI 49074
Contact Person: Jennifer Harrison, LMSW, ACSW IDDT Coordinator
Phone: (269) 553-8014 (direct) (269) 553-8000 (administration main)
PCA#: **Contract #:** **Federal ID:** 38-3313413

The Southwest Affiliation of Allegan, Cass, Kalamazoo, and St. Joseph Counties is committed to aggressively transforming our system of administration and care delivery to one focused on the expectation of co-occurring disorders (CODs), effective and efficient consumer identification and referral, and the full implementation of models of care including Integrated Dual Disorder Treatment (IDDT) in high fidelity programs for the most vulnerable consumers. The Affiliate continues to focus on groundwork activities while at the same time moving forward with IDDT readiness and implementation in several settings throughout the PIHP.

A. System Transformation Efforts

- Development of action plan based upon CO-FIT results with two specific Performance Improvement Teams (PIT) focused on increasing availability for wet, damp, and dry housing options as well as universal screening for co-occurring disorders
- Participation as a demonstration site in Co-Occurring Center of Excellence (CCOE) technical assistance to improve screening processes for COD
- Conclusion of strategic-planning group (along with Peer Support Specialists) for crisis stabilization and emergency services that are dual disorder capable and do not contain arbitrary limits to access, admission, or services based upon illness or readiness to change

B. System Change Process Activities

- Proposed policy change regarding Emergency Mental Health services changing practice related to not assessing consumers until below the legal blood alcohol limit (.08) to behavioral indicators of "conscience, coherent, and cooperative" as well as PIHP-wide policy regarding welcoming practices related to assessment and treatment services with consumers who may be intoxicated ready to go to Quality Leadership Team and PIHP-wide Utilization Management for approval
- Training offerings intentionally targeted toward peer and non-peer staff , as well as clinical and non-clinical staff in development and execution of training plan
- Consultation with Dr. Chris Cline featuring physician education, meeting with medical director, Performance Improvement Teams (part of IPLT) and PIHP Executive and Clinical directors re: revising Charter document

C. Milestones Achieved

- 7 self-identified COD peers now certified as Peer Support Specialists in Michigan
- Key role in efforts to provide added services to MiFAST team to allow consultation and technical assistance as follow-on services to fidelity assessment within Michigan
- Following receipt of MDCH Block Grant for Recovery Shoppe/Recovery Enterprises/Recovery Institute, applied for additional funding for space costs, "Getting to Work" apprenticeship stipends, public transportation passes for newly employed consumers with SMI at Ministry with Community, and 2 additional PSS staff to be part of Recovery Team to Kalamazoo Community Foundation and Fetzer Foundation
- Sharing of training and consultation resource with adjacent PIHP, Venture Behavioral Health, including joint piloting of UNCOPE screening measure for adults and adolescents being assessed for mental health condition
- Increased resources and availability of a COD:IDDT resource library for use throughout the PIHP, and forwarded to MDCH for use throughout the state

D. Consensus Building

- Consensus of KCMHSAS medical staff about 1) utilization of Client Benzodiazepine Agreement, 2) piloting of DALI-14 in medication clinic for all new consumers (starting Feb 1, 2007), and 3) training and registration of KCMHSAS medical staff to be Suboxone providers (by March 31, 2007). Also shared training resources from Dr. Christina de los Reyes with several additional medical staff planning to attend Spring training in West Michigan
- Consensus regarding central service population of Recovery Institute and other peer-to-peer recovery initiatives being available to consumers regardless of presenting or multiple illnesses
- Consensus with Access staff supervisors re: implementation plan for COCE demonstration site project, including persons responsible and how IT and training will be utilized in project

E. Utilization of Systems Assessments Update

- Finalization of initial performance improvement projects based upon CO-FIT results over two administrations
- Use of IDDT Readiness assessment with use of Deb Myers of Ohio SAMI CCOE to consult with Stephanie Lagalo of InterAct re: fidelity baseline follow-up steps for InterAct IDDT workteam
- Based upon PIT projects, participation of IDDT Coordinator in local Housing Resources team to determine more effective menu of housing options for consumers with COD at various stages of readiness

F. Training and Technical Assistance

- Technical assistance calls with Deb Myers and Stephanie Lagalo as part of GLATTC Leadership Institute
- Training for PIHP (also invited staff from Network 180 and Venture) re: Introduction to IDDT and COD treatment in group and family settings. 135 attending October 19th training, 63 attended November 14th
- Team Leaders from each county in PIHP (from two provider organizations in Kalamazoo) attended IDDT Program Leader training with Ric Kruzeski and Patrick Boyle December 5, 6
- One physician and IDDT Coordinator attended Dr. Christina de los Reyes IDDT Physician training in Ann Arbor November 28
- SW PIHP facilitated Learn and Share October 22

G. Barriers to Implementation

- Lapse in Allegan ACT Team Leader from May - October 2006 (Karen Feaster hired October 2006)
- Information system's dissimilarities (Carenet and CMS). New integrated system in development with plans to launch Phase 1 October 2007; until then changing current programming is difficult and cost prohibitive

- Visibility of Certified Peer Support Specialists in Kalamazoo; they are so extraordinary that they are in tremendous demand to provide assistance to other systems; this makes peer efforts in SW Michigan difficult to maintain consistently

H. Implementing Enhanced Service Model

- Baseline fidelity assessment completion by InterAct of Michigan on SAMM team July 2006. Based upon findings, recommendation approved to implement IDDT on ACT Team 3 at InterAct effective November 1, 2006. Changes made to process of authorization and assessments for SAMM so that program can continue to be a Dual Disorder Enhanced (DDE) program for Quadrant III (high SUD, low MI) consumers. InterAct IDDT workteam completing crosstraining of stage-matched group offerings, and forms transition to include requisite portions of IDDT EBP.
- Douglass Community Association identified IDDT team leader Jeanette Bayyepuneedi, LMSW as primary contact.
- Allegan ACT focused on preparation for IDDT by training team leader Karen Feaster in model; and Woodlands (Cass) Kathy Boes and Steve Lehman determining portions of IDDT that can be implemented in rural county

I. Financial Support and Sustainability Planning

- Substance Abuse PA2 funding continues to be available this FY as a non-required local match to support IDDT and system transformation activities
- Discussions regarding assuring system change and EBP implementation following grant period end on-going
- Plans to re-submit SAMHSA Peer-to-Peer Recovery Community Services grant application to provide funding for a peer recovery agency to serve individuals with single or dual disorders in Kalamazoo

J. Next Quarter Activities

- Participation of increased PSS in Learn and Share Activities from Kalamazoo (5 planning to attend January session)
- Determination of availability of peer-to-peer recovery federal grants for reapplication
- Training
- On-going twice monthly "mini-training" and supervision of Access, Mobile Crisis and Response Team (MCIT), Emergency Mental Health (EMH) clinicians, and Information and Referral staff on COD screening, utilization of welcoming principles, motivational enhancement strategies, and consumer staging
- Planned integration of Welcoming training to non-clinical Access staff throughout PIHP including provider support staff
- Development of integrated assessment format to be programmed into Carelink system with components of Integrated Longitudinal Strength-based Assessment (ILSA) (narrative format, most recent stable baseline, and stage of readiness and goals per presenting concern) and current assessment format (required fields, eligibility, demographics, releases for care coordination)
- COD Introduction training to Finance, IS, Quality, and Support Staff PIHP groups in collaboration with consultant Mary Dengerink

1. **Project title**: Integrated Dual Diagnosis Treatment (IDDT)

   Contract number: 38-2056235 (LifeWays fed ID #)

   Project number: 06B1MICMHS-03 (federal grant award #)

   Time period covered: 10-01-06 to 12-31-06

   MDCH Specialist: Karen Cashen, Adult Block Grant Coordinator

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

   The IPLT is a strong committee that continues to work together as a team by monitoring membership, reviewing bylaws and implementing new process for reviewing EBP's within the LifeWays network provider organization. Some members of the team continued to be absent which effects the overall functioning of the team.

   The IPLT currently has three EBP's which they are working on developing, implementing and/or monitoring which include the FPE, IDDT and Peer-Support Specialists. This quarter began with the IPLT using the stages of change worksheet to determine what needs to be done in order to implement a Peer-Support Specialists program within the LifeWays network provider organization.

   In regards to IDDT specifically the EBP Coordinator organized a two-day conference with Drs. Minkoff and Cline. The two-day conference brought together key stakeholders to discuss the organization, development and implementation of IDDT within Jackson and Hillsdale County.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

   LifeWays which is the PIHP is collaborating with Mid-South Substance Abuse Commission the CA to assist the systems change process for the integrated services (IDDT). The CEO, Medical Director and Clinical Director participated in the two-day conference with Drs. Minkoff and Cline and it appears everyone is on board with the systems change that will be needed to support IDDT throughout

the system. The IPLT is the committee within the PIHP that helps develop, monitor and implement any new evidence base practice treatment. IPLT is lead at this time by the Clinical Director and the team includes representation from the Finance and Quality Department of the PIHP. In addition the Executive Director from the local CA attends and participates in the IPLT monthly meetings.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

   LifeWays hosted a two-day conference that brought together key stakeholders to discuss the development and implementation of an integrated system. In addition the IPLT met with Drs. Minkoff and Cline to discuss how to proceed from this point forward. At this time the IPLT and the Leadership from LifeWays are meeting to determine what steps will need to occur consensus development, policy direction and chartering of quality improvement activities along with identifying overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

   The education during the 1st quarter has targeted Mental Health and Substance Abuse providers. We do plan on expanding education to include primary health care providers and other community stakeholders.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

   The CO-FIT has not been done yet however it should be completed within the next quarter.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

The COMPASS has not been implemented yet however, an implementation plan will be developed in the next quarter

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

   We are integrating the quality improvement process into the IPLT which includes IDDT Subcommittee. Over the next 2 quarters we will be developing targets, indicators and monitoring systems related to the IDDT.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

   No policies and/or procedures have been developed at this time however, within the next 6-8 months there will be polices and procedures in place that will support the develop and implementation of an integrated system.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

    Teams have not been identified as of yet however, the teams should be identified by beginning of year two of this project.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

    This process will begin in year two.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate**

universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

This process will begin in year two.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

    At this point, no barriers have been identified.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

    Our Evidence Based Practice Coordinator resigned in November. These duties are being transitioned to the new Clinical Director as well as part time assistant. The new Clinical Director will need to be educated on the model.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

    Because we are in the initial phase, we have not had implementation problems, but we did submit an amended budget due to the resignation of the Coordinator.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.**

    -Develop IDDT Subcommittee
    -Complete the GOI and CO-FIT
    -Implement the results of these into the Work Plan
    -Write and issue the RFP for IDDT implementation
    -Providers selected
    -Have Access and Service Entry staff trained to assess for Dual Diagnosis

17. **What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?**

    The embedding of IDDT service delivery into the LifeWays Provider Network. This will be accomplished by "piloting" 4 teams with the grant support and then expanding to include all of the appropriate LifeWays Providers.

Report Completed by: Diane Cranston
Clinical Director
517-780-3368

Michigan Department of Community health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-Occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

Report period:	October 1, 2006 to December 31, 2006	
PIHP:	Macomb County Community Mental Health (MCCMH)	
Program Title:		
Executive Director:	Donald I. Habkirk	
Address:	10 North Main, County Building - 5th Floor, Mt. Clemens, MI 48043	
Contact Person:	Robert Slaine, Deputy Director	
Phone: 586-469-****	Fax 586-469-7674	E-mail: bob.slaine@mccmh.net
PCA#:	Contract #:	Federal ID:

A) Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practice Leadership Team

- The IPL Team met three times in this quarter. It continued to address issues surrounding the IDDT COD EBP initiative, physical health care monitoring and coordination (especially in regard to the metabolic syndrome and similar effects associated with the use of atypicals), peer support training and development, and self-determination implementation.

- An IPL sub-group was formed regarding screening for co-occurring disorders through the MCCMH Access Center, which serves the behavioral health provider network, and through CARE, the AAR for the MCOSA substance abuse provider network.

B) Briefly describe the Systems Change process activities during this quarter related to the integration of Mental health and Substance Disorder services and the impact of the EBP process on creating systems change.

1) Members of the IPL continue to attend on-going state-wide training sessions and committee meeting associated with the implementation of the IDDT COD EBP
2) MCCMH staff continue to be active participants in the Network 180 grant with COCE regarding screening and assessment. MCCMH is planning to participate in the implementation of pilot processes for screening for COD. These processes will include methods for tracking the results of screening activities and the use of appropriate motivational interviewing techniques during the screening process to maximize the transfer of information.
3) MCCMH implemented a new Electronic Medical Record (EMR) on October 1, 2006, which includes the UNCOPE screening tool. This tool is now being utilized by Access Center and clinical staff in their interactions with consumers.
4) IDDT leadership staff have met repeatedly with representatives of select providers who will implement the SAMHSA EBP "toolkit".
   a) Meetings with two provider organizations have led to plans for the development of IDDT teams in early 2007. In-depth discussions addressed the range of expected services, the competencies and roles of staff, expected service rates, and preliminary costing of the implementation process. Both provider organization have been active in the planning process and are ready for the final contracting process.
   b) Meetings with two other provider groups have occurred at multiple levels. There

have been meetings with the staff of these provider groups to describe the context and purpose of the toolkit implementation process and to seek out information regarding potential barriers so that appropriate solutions to those barrier's can be forged. Other meetings with the leadership of these provider groups have led to the development of a training series that will be implemented from January through May of 2007 to build staff capabilities for the delivery of IDDT COD services.

c) Meetings with a fifth provider were postponed midway in the planning process due to organizational changes at that provider organization.

C) Briefly describe the changes that have occurred and milestones achieved in the last quarter. Attach the products developed.

- See item B above.

D) Briefly summarize consensus building and collaborative service efforts with other systems and agencies that have taken place during this quarter.

- The close working relationship between MCCMH and MCOSA leadership teams contributes to and is supported by the focus on implementation of the IDDT-COD.
- Meetings between leadership staff of MCCMH and of Macomb DHS, Macomb ISD, and Macomb Juvenile Court/Juvenile Justice Center, the Macomb Prisoner Re-entry Initiative community team, and the Macomb Homeless Coalition have included discussion of the SAMHSA IDDT and how the implementation of the EBP would both assist and be aided by each of these other organizations.
- See Item "B 4)" above.

E) Briefly describe the progress of each of the Co-occurring Disorder project goals and objectives of this quarter (Quarter 5).

1) MCCMH and MCOSA staff continue to participate in state-level meeting regarding the initiative, including "learn and share" and sub-committee meetings. MCCMH is an on-going participant in the COCE project spearheaded by Network 180.
2) MCCMH and MCOSA convene meetings with other stakeholders including Substance Abuse Coordinating Agency providers to address co-occurring disorders.
   a) Meetings this quarter have focused on organizations that will implement the SAMHSA COD "toolkit" and Dual Disorder Enhanced services. Some of these organizations are enrolled on both the MCCMH behavioral health provider panel and on the MCOSA substance abuse treatment provider panel.
   b) Meetings with the MCOSA provider panel membership is currently scheduled to occur in the next quarter.
3) MCCMH / MCOSA offers updates regarding Co-occurring Disorders and IDDT to regional systems and stakeholders.
   a) The trainings by Dr. Mee-Lee in October and by Michael Clark in December were widely advertised. Some of the participants in these training were staff from other systems of care, including, for example, staff from local drug courts.
4) MCCMH / MCOSA coordinate / ensure training on at least one major topic of IDDT model (e.g., psychopharmacology in co-occurring treatment, stages of change and motivational interviewing, stages of change model and motivational interviewing, stage-related group treatment with persons with co-occurring disorders) per quarter
   a) As noted under the section on training, both Dr. Mee-Lee and Michael Clark provided large-scale training in this quarter. The former provided information on the IDDT COD EBP initiative, welcoming, engagement, and screening. The latter delivered a workshop specific to motivational interviewing.

b) Conferences between MCCMH project leadership and provider staff from several agencies included clarification of the IDDT initiative, an overview of processes and skills measured by fidelity measures, and methods of transition for staff into the treatment of co-occurring disorders.

5) MCCMH / MCOSA works closely with the Macomb Homeless Coalition as it plans the implementation of a Safe Haven to ensure that IDDT treatment will be available for those entering that service.
   a) The Macomb Homeless Coalition is still awaiting word from HUD on the funding of the Safe Haven project.
   b) MCCMH has begun implementation of a 2006-2008 DCH Block Grant for a Homeless Outreach Team. This has included brokering discussions between the potential provider of that service and representatives of the Macomb Homeless Coalition. It is expected that the Homeless Outreach Team will implement Dual-Disorder Enhanced capability as it begins linking directly with organizations that are part of the Macomb Homeless Coalition.
6) MCCMH / MCOSA works closely with the M.A.C.O.M.B. Project (the Macomb County pilot project for the Department Of Correction MPRI) to ensure that IDDT treatment will be available for those entering the community from prison.
   a) MCCMH/MCOSA staff continue to be active on the Steering Team of the local MPRI project. The local MPRI project has recently hired a new Coordinator and is re-structuring some of its activities to coordinate its services in a more effective manner with mainstream providers such as MCCMH and MCOSA.
   b) MCCMH has also been active in working with the state-wide Mental Health MPRI Project managed through Lifeways. This activity includes not only case coordination on behalf of individuals, but also development of contractual arrangements for the implementation of the MH MPRI project.
7) MCCMH / MCOSA, with participation on the Measurement Subgroup of the EBP initiative, develops / pilots utilization management tools regarding entry into services for persons with co-occurring disorders.
   a) MCCMH staff participate in the Measurement Subgroup of the EBP initiative, including its discussions of broad outcome measures for the initiative. Further meetings of this committee will be needed for finalization of the selection of appropriate outcome measures. Implementation of the outcome measures will facilitate appropriate utilization management for the initiative.

F) Briefly describe staff training and technical assistance obtained during this quarter. Explain how these will be utilized for the for program development and improving services. Please include staff coverage for the project with an organization chart showing the location of staff for this project.
   c) MCCMH sponsored a system-wide training by Dr. Mee-Lee in October, 2006, which was attended by approximately 130 staff and administrators from providers on the MCCMH behavioral health panel and on the MCOSA substance abuse provider panel. Feedback from the training was very positive. Dr. Mee-Lee was scheduled for two days of follow-up training in early January, 2007, and enrollment in the training has been robust. Dr. Mee-Lee will also address MCCMH psychiatrists in a separate evening meeting during the training scheduled for January, 2007.
   d) MCCMH sponsored a two-day training in Motivational Interviewing by Michael Clark in late November - early December, 2006. The session was filled and evaluations of the training by participants indicate positive results. A second two-day training session has been scheduled for January, 2007, as a repeat of the "Motivational Interviewing 101" material presented in December, 2006. A third two-day training session is being scheduled for May, 2007. It will recruit participants from those who have been trained in the first two

training sessions and will provide them more in-depth ("Motivational Interviewing 201") skills.

e) MCCMH engaged in a day-long consultation with Dr. Cline in late November, 2006. This consultation was developed with assistance from DCH representatives (Tison Thomas, whose assistance was greatly appreciated). The consultation included the following:
   a) discussions of the overall implementation plans for the project, including those for the programs implementing the SAMHSA toolkit, those programs building Dual Disorder Enhanced capability, and those preparing to deliver Dual Disorder Capable services,
   b) discussion of the processes of screening for co-occurring disorders in the MCCMH and MCOSA systems,
   c) discussion of the issues regarding psychiatric prescribing and psychopharmacology as part of the initiative for co-occurring disorders,
   d) discussion of policy development and quality improvement processes.
   e) a meeting between Dr. Cline and representatives of the various programs preparing to implement the SAMHSA toolkit for COD.

G) Briefly describe the barriers and issues encountered during this quarter and the action taken to address them (administrative, legal, policy, training, outcomes, funding, budget, data encounter, grievances, etc.)
- Discussion in state-level and local workgroups regarding screening and assessment has been time-consuming. The shift in focus from screening instrument to screening process has been helpful. Participation in the COCE Project of screening processes is on-going, with pilot processes slated to begin in the next quarter. Discussions regarding screening instruments was helpful in preparing for current implementation of the screening tool (UNCOPE) built into the new Electronic Clinical Record being implemented by MCCMH.
- Discussion in the state-level Measurement Sub-committee has not yet led to the identification of outcome measures for the initiative. MCCMH's implementation of a new EMR in October, 2006, is progressing well and will provide opportunities for data aggregation and analyses, but further development of utilization management methodologies will require sufficient time for data entry into the system to achieve sufficient critical mass.

H) For projects that are at the stage of implementing COD enhanced service models, provide the following information.
   1) Briefly describe the PIHP action related to data collection, fidelity, and process monitoring activities to accomplish the project goal
      - Providers are currently planning for implementation of the IDDT tool-kit models and are preparing for fidelity adherence.

   2) Describe the target population / program served during this quarter. Include the number of unduplicated individuals this quarter and the cumulative number of unduplicated individuals during the fiscal year. (If possible, include the demographic of diagnostic data relevant to the project's goals).
      - MCCMH is in the initial process of implementation of the IDDT COD EBP and is not yet ready to identity consumers served according to the guidelines of that EBP.

I) Describe PIHP financial and in-kind support utilized to support this project and status of sustainability planning. Is the project having problems with implementation / continuation with all the allocated resources. Should an amendment be initiated?
   1) Substantial time and travel commitments for leading staff have been assumed by

MCCMH in this initial quarter.

2) The request a carry-over of funds from year one to year two of the initiative has been made. The request included the following components.
   a) Up to $5,000 to assist in the fidelity monitoring assessment process being coordinated by Wayne State University.
   b) Funds for the development and implementation of a professional campaign to formalize and assist the roll-out of integrated treatment for co-occurring disorders across the provider panel, including materials and processes to improve knowledge and behavior of an internal audience (service providers), an external audience (consumers), and the public in general.
   c) Consultation and technical assistance for each of the following audiences
      (i) psychiatrists (1 day) ,
      (ii) the teams implementing the IDDT model (2 days) ,
      (iii) the programs committing themselves to be DDE (Dual Disorder Enhanced) providers (2 days) ,
      (iv) the providers of Access and Referral services (1 day), and
      (v) those developing policy and workforce development for the implementation of the co-occurring initiative (1 day).
   d) Consultation and assistance with the modification and integration of the two electronic information systems used by MCCMH (PCE) and MCOSA (CareNet) in order to permit
      (i) the sharing of appropriate information regarding screening, assessments, services, and outcomes, and
      (ii) the use of "expert systems" that can guide clinical performance (e.g., integration of drug interaction information with prescribing) and
      (iii) the development of co-occurring disorder treatment modules for the websites of MCCMH and MCOSA..
   e) Funds for training, guided by the McBap certification for supervisors, specifically for supervisors who will guide staff that implement co-occurring disorder services.
   f) Funds for the acquisition of materials regarding co-occurring disorders that can be used by consumers, their families, and staff.

J) Describe the activities planned to address the project's goals and objectives for the next quarter.
   1) Initiation of the IDDT EBP COD services by provider agencies on the MCCMH Behavioral Health provider panel. These provider organizations will be asked to provide representatives to a sub-group of the IPL which will focus on the implementation process.
   2) Continued participation in the COCE project regarding screening and assessment. This will include a pilot process for the data collection tool presented by Network 180 and a test of the use of motivational interviewing strategies during the screening proces.
   3) Dr. Mee-Lee is scheduled to two day-long training session to provider agencies from both the behavioral health and substance abuse provider panels regarding integrated services, welcoming, screening and assessment, and treatment planning in early January, 2007. He is also scheduled to speak to psychiatrists regarding their role in the implementation of the COD initiative in a separate meeting. .
   4) A second two-day training on Motivational Interviewing will be delivered in January, 2007, within Macomb County for supervisors and line staff of agencies on both the behavioral health and substance abuse provider panels.
   5) Two provider groups preparing for the implementation of the IDDT SAMHSA toolkit will begin a series of training session in February, 2007. This training series will continue through May of 2007. In addition to staff who will implement the "toolkit', the training will include supervisors and staff from outpatient clinic settings in the same provider

organization. This will facilitate the implementation of Dual Disorder Enhanced services in the organization in addition to the implementation of the "toolkit" teams.

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-Occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

Report Period: October – December 31, 2006
PIHP: Lakeshore Behavioral Health Alliance
Program Title: Integrated Dual Disorders Treatment
Executive Director: James Elwell
Address: 376 Apple Ave. Muskegon, MI 49442
Contact Person: Teri Smith
Phone: 231 724-4592 Fax 231 724-6042 e-mail: smitht@cmhs.co.muskegon.mi.us
PCA #20708 Contract # 20071297 Federal ID #38-6006063
MDCH Specialist: Tison Thomas

2. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.

During the first quarter of FY06/07, the Affiliation Improving Practices Leadership Team (IPLT) continued to meet on a monthly basis. The team concentrated much of its efforts on identifying concrete steps needed to transform our CMH's into Recovery-based organizations. Much constructive input and direction was given to the Affiliation Recovery Task Force.

IPLT members reviewed and discussed recovery articles that focused on the interrelationship of Recovery principles and organizational structure and the strong positive relationship between Person-Centered Planning and the delivery of Recovery-oriented services. The IPLT has recommended and supported the drafting of a detailed description of specific concrete recovery actions, behaviors, and language to guide CMH staff in their day-to-day interactions with consumers and their family members. It has facilitated the offering of Wellness Recovery Action Planning (WRAP) groups to CMH staff and will explore the usefulness of the ROSI in assessing our recovery efforts.

In addition to its involvement with the Affiliation Recovery efforts, the IPLT has been assisting Evidence-Based Practice Implementation teams in developing realistic plans for sustaining and expanding Parent Management Training Oregon Model (PMTO), Family Psychoeducation (FPE), Integrated Dual Disorders Treatment (IDDT), and Recovery/WRAP after the mental health block grants run out. It is aggressively supporting the training of staff and consumers who are certified in FPE, PMTO, and WRAP to become trainers in their respective Evidence-Based Practice.

IPLT members have reviewed and discussed the growing crisis of premature death among persons with serious mental illness due to chronic health problems and have educated

Affiliation senior leadership regarding it. Muskegon CMH, as a result, has made consumer wellness a clinical priority for FY06/07, and is in the process of educating line staff regarding the metabolic syndrome and achieving a healthy lifestyle.

3. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by the system leadership?

   CMH administrators and the Coordinating Agency director coordinate service and system administration. The identified leaders are: Jim Elwell, Muskegon CMH Executive Director; John North, Chief Operating Officer; Glenn Eaton, Clinical Director; Gerry Cyranowski, Ottawa CMH Director; Sue Buist, Program Director; and Karen Youngs-Hartly, Director, Lakeshore Coordinating Council. The CA director has been invited to Consensus Document meetings and community collaboration initiatives. She has designated Mark Rankin, manager of the CA's assessment center for the two counties to attend workgroup meetings. He has been very helpful, in assisting with eligibility and understanding substance abuse treatment system operations. Dr. Ken Minkhoff has challenged the CMH executive leadership, the medical director and CA administration to further commit to development of the IDDT team and dual disorder capability. At this time, the assessment and treatment planning for persons with co-occurring disorders is not integrated in one assessment center. However, progress has been made in coordinating care for the more complex dual disorder cases.

4. Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).

   Five drafts of a Lakeshore Behavioral Health Alliance (LBHA) Consensus document were developed during 2006. The latest draft was modified and accepted for current practice in September 2006. It was decided by the workgroup, at that time, that we would leave the document "as is" and re-visit it after a period of time when we could further evaluate its effectiveness. The coordination of care between substance abuse providers and CMH staff has been complicated by staff changes at the agencies and some tension with our CA. However, a CA representative has participated in inter-agency meetings and the design of the consensus document.

   County specific workgroups are executing the consensus principles as they apply in their area. Priorities at this time include: continuing to build consensus internally and with community partners, developing organizational structure to support IDDT services, and providing COD and related training for staff. Please see attachment Consensus Draft #5.

5. Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stake holders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.

Both Ottawa and Muskegon CMH's have participated in system improvement meetings, workgroups, etc. In Muskegon County, staff are working with a Corrections Inter-Agency Community Services Workgroup to address jail diversion, assessment services, the need for detox, and other issues. This past quarter, the workgroup took the lead on a document defining care for mentally ill and dually diagnosed consumers with police involvement. Modeled after an inter-agency agreement developed in Ottawa County between police, hospital emergency room and CMH, the new Muskegon Mental Health/Law Enforcement Policy is being implemented in a similar manner. Police department officials from Muskegon County will now sign on to this document.

Consumers have been involved in the IPLT meetings and various workgroups. The Past-President of the Muskegon NAMI Group attends the IPLT meetings and provides very helpful input. Ottawa County COD workgroup includes the following agencies: Pine Rest, Pathways, Catholic Social Services, Zeeland Hospital, Holland Hospital, North Ottawa Hospital, OAR, Drug Court, Shoreline Consultation Services, Intercare, Holland Rescue Mission and consumer advocacy groups. Additionally the IDDT steering committee of Ottawa County has been instrumental in advocating and assisting consumers in the implementation of a Dual Recovery Anonymous group.

6. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?

The PHIP has not completed a CO-FIT during this quarter. The focus has been more on developing internal competency and dual disorder capability.

7. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?

An initial COMPASS was conducted a year ago and work plans have been developed to address areas needing quality improvement efforts. At this time, both counties are continuing to work on originally set goals. A list of gaps/service needs was developed in May '06 as a guide for system improvements.

8. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question # 4 above?

Each county's steering committee works within the management structure and clinical leadership to bring dual treatment issues to the forefront. Quality improvement efforts are integrated with training and clinical supervision goals. Examples of treatment issues that are being addressed in both counties are: welcoming, recovery principles and the development of WRAP groups, stages of change, treatment planning training and motivational interviewing training. Coordination with the CA has addressed prioritizing education for staff on the four quadrants and setting eligibility and resource knowledge for both counties. Mark Rankin from the CA Assessment Center has been helpful in both counties providing a link to information and developing resource and treatment planning with substance abuse agencies. Ottawa CMH has developed a preliminary list of potential IDDT consumers and eligibility criteria for this program. The IDDT tool box outcome measure may be used. The psychosocial assessment tool used by both CMH's has been revised to better capture information regarding dual disorders and stage of change. The Muskegon clinical workgroup coordinated a survey of staff case loads in order to identify consumers with substance use disorders and their stage of change. This information will be used to examine possible program changes and staffing structure. As staff become more knowledgeable of substance abuse identification and interventions, further eligibility will be clarified.

9. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.

   Muskegon CMH has recently developed a revised clinical supervision policy. Job descriptions and competencies are being re-written to include recovery language and dual diagnosis capability. A joint PHIP workgroup was convened during December of 2006 to develop an Affiliation Psychosocial Assessment tool, which will include much improved recovery language and dual disorder assessment capability.

10. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.

    Both counties are currently working to identify staff for specific IDDT teams. During December, three staff from Muskegon and two from Ottawa attended the training in Ann Arbor, conducted by the Ohio CCOE staff. The training was very helpful and gave staff excellent resource materials.Program descriptions have been revised in Ottawa Co. to reflect welcoming of individuals with co-occuring disorders. The "inactive consumers" policy has been revised to reflect welcoming of individuals who require episodic care. A continuing concern of CMH Senior Management is the cost of creating a team with a reduced case load size, given capacity issues for both CMH programs.

11. What activities are in the process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter? Both Counties are evaluating staffing options and development of improved services.

    On November 30, 2006, Dr. Ken Minkhoff met with LBHA representatives for consultation and training. Steering committee members and identified staff also attended the Ohio COCCE training in Ann Arbor in December. Ottawa CMH is currently engaged in designing a team to serve dual clients. Decisions have not been finalized to change structure. Muskegon CMH is currently focusing all of its efforts on developing dual disorder capability and then will address the feasibility of implementing an IDDT Team.

12. What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

    Both CMH's have under taken efforts to improve clinical competency. At Muskegon CMH, a clinical supervisor workgroup has been meeting for four months to review information, discuss clinical supervision efforts and support further development of dual disorder skills. A training date for substance abuse education for all case managers has been set for January 2007. During December, 60 Muskegon staff attended an introductory workshop on motivational interviewing with Michael Clark MSW. Clinical staff from both CMH's have participated in trainings with Dr. Ken Minkoff, Dr. Mee-Lee and will have a 24 hour course on Motivational Interviewing with Michael Clark during the next six months. Ottawa CMH has scheduled a pre-assessment readiness evaluation with Patrick Boyle on February 22nd or 23rd. Ottawa clinical staff have had several on-going, monthly clinical discussion groups to review treatment approaches with dual consumers. Both CMH's are also exploring the development of Discovery Groups for consumers not ready for treatment action programming. An Affiliation project team recently completed a uniform psychosocial assessment tool incorporating recovery language and stage of change approaches.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

There seems to be some confusion regarding DCH requirements in the Person Centered Planning process, versus the clinical education being provided regarding motivational interviewing and appropriate treatment planning based on stage of change. There seems to be apprehension that DCH site reviewers expect to see thorough treatment plans, which may address needs, but not be attuned to the clients wishes and stage of change. There is also confusion regarding billing and processes to merge substance abuse dollars and codes. CMH staff charged with Gatekeeping and being concerned about costs, continue to limit care for some consumers who will be difficult to engage—and then cost more in the long run. Ottawa staff continue to focus on staff capability. For both CMH's, staff identified for IDDT work will need further support and skill building to improve service delivery and outcomes for consumers. It would be helpful if state leaders directing evidence based practice and site reviewers merged expectations and were clearer to the CMH staff by creating some uniform expectations for CMH's. Unfortunately, staff have legitimate concerns that they spend too much time on paperwork, and not enough face to face time assisting consumers in meeting their goals.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

    The state has been very helpful with making available technical resources for participating agencies. Further assistance with coordinated assessment, codes that are not complicated and streamlined billing and outcome development will be helpful.The CMH systems tend to operate in departments of prescribed service and sometimes have difficulty re-organizing and building teams in a different manner. Concerns have been expressed about the cost of creating a team serving a smaller case load, and then having other staff taking on larger case loads to compensate. The end of November, Dr Ken Minkhoff, was very helpful in assessing our two CMH's and where some of the significant barriers are.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

    Additional block grant dollars will be critical to further the work of this effort. The current $35,000 per year, has given LBHA the opportunity to start the process and improve staff capability. However, meeting the Fidelity for an IDDT team and the desired outcomes is a more intensive project, with many complicated steps. Once an IDDT team is established, the members would greatly benefit from further skill building and consultation. These are some of our most costly and complicated consumers, so highly trained staff will be essential for achieving the desired outcomes.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

We will be continuing with the action plan as stated. Both CMH's are expending considerable time and energy to develop motivation counseling skills via the training from Michael Clark, MSW. The steering committees of each CMH and their clinical workgroups will continue to encourage the daily work of improved competency and service. The next quarter may be critical in each county, with decisions made regarding future agency structure and staffing. The steering committee membership's knowledge and commitment sometimes surpasses the readiness of administration and the agency structure to change. More effort must go into consensus building with Senior Management in order to bring about more rapid organizational change.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

Further development beyond this period of block grant funding will be determined by two factors: A) The level of each CMH's commitment to the development of a specialized IDDT Team and whether there is further funding or not; and, B) If there is further funding to assist with IDDT Team development, how well does each CMH prioritize and support the work of this specialized team.

At this point, both agencies are building a critical mass of dual disorder knowledge, and staff are becoming more attuned to the need to assess and address the substance abuse issues of their assigned consumers. Each CMH currently has some identified staff expertise and a beginning level of dual disorder programming in place. It is hoped that further expansion of dual disorders treatment services will occur and will remain a priority.

This report was prepared by:
Teri Smith, Dual Project Coordinator, Muskegon CMH, (231) 724-4592
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IDDT Quarterly Report

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

Network180 has continued consultation with Dr. Ken Minkoff and Dr. Chris Cline. The structures created to support the development and implementation of CCISC remain in active and involved. These include the CCISC Leadership Team, the CCISC Team/Trainers, and the CCISC Curriculum Group.

The Improving Practices Leadership Team (IPLT) continues to meet on a monthly basis. The IPLT has been following the Action Plan that was developed in 2006 and has focused on the following activities:

- Review of evidence based practice (EBP) currently in use in our system. To date, the following EBPs have been reviewed:
  - Motivational Interviewing
  - DBT
  - Treatment for DD Sex Offenders
  - Supported Employment
  - Recovery Management
  - McFarlane's Multi Family Psycho Ed

- The Improving Practices Leadership Team has not confined its review to established EBPs, but is also reviewing emerging practices that are not researched based.

- The IPLT Data Team, which is made up of Network180 and provider staff, are in the process of reviewing the data that is available from the Network180 system and provider system regarding evidence based practices.

- Network180, in cooperation with Grand Valley State University, developed the Evidence Based Practice Survey Report. The report is based on a questionnaire that was sent to all of the Network180 service providers. A copy of this report is attached.

- The Improving Practices Leadership Team received regular reports from the Recovery Council, from the Network180 Research Committee, and from the My Fast Representative who sits on the Improving Practices Leadership Team.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

Network180 is the PIHP, the CMH, and the CA. The CCISC Leadership Team is made up of the Executive Directors of a number of mental health and substance abuse

providers for adults and children's services. The role of this group is to guide and lead the CCISC implementation in the Network180 provider system.

Mike Reagan	President, Proaction
Jack Greenfield	President, Arbor Circle Corporation
Greg Dziadosz	President, Touchstone innovare
Sharon Loughridge	President, DA Blodgett
Al Jansen	Pine Rest Christian Mental Health Services
Tom Moore	Clinical Supervisor, Life Guidance Services
George Tyndall	Clinical Supervisor, Bethany Christian Services

Network180 has encouraged the involvement of Medical Directors and psychiatric staff in the CCISC initiative. The Medical Directors and psychiatrists have met with Dr. Minkoff and Dr. Cline on each of their visits to Network180.

The Improving Practices Leadership Team has Network180 representation from the MISUD Adult Team and the Children's Team. There are also representatives from the mental health and substance use disorder treatment systems, adult and children.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities** that have been adopted (e.g., welcoming, screening, data collection, etc.).

Network180 has developed the CCISC consensus document 2007 (see attached). It is anticipated that this document will be signed by all of our mental health and substance abuse providers of adult and children's services.

In 2006, the system priorities for Network180 included welcoming, screening, and data collection. A process improvement team was convened to address each of these areas. A collaboration between the Screening and Data PITS lead to the development of the COD Data Project. This project is designed to determine the prevalence of diagnosed COD, as well as Pre COD. Pre COD has been defined as the presence of indicators that fall short of meeting the DSM IV criteria for a mental health and a substance use disorder. It was determined that this information was valuable to service planning, client placement/referral and clinical interventions. See # 8.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

Network180 is committed to collaboration with community providers and partners. Network180 staff members participate in the following collaboratives:

- Vision to End Homelessness-
- StreetReach Community Advisory Team-housing, physical health, police department, homeless services
- StreetReach Stakeholder Group- housing, shelter system, police department, community health centers, DHS, employment services

- Kent County Family and Children's Coordinating Council-DHS, service providers
- Prostitution Roundtable-61st District Court, Social Work and Police Partnership (SWAPP), service providers, housing

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

Network180 completed the CO-FIT in September 2006. Network180 administrative staff, Access Center staff, and Contract Managers from the MISUD Team and the Children's Team participated. In discussion with the CCISC Leadership Team, it was determined that before we developed any process improvement teams from the CO-FIT, that we should develop a long range plan for CCISC. The CCISC Leadership Team held two half-day planning sessions and developed three goals with timelines.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

The CCISC Consensus Document 2007 provides for an incentive for completion of the COMPASS on an annual basis, and development of an Action Plan based on the COMPASS. The providers conduct the COMPASS independently; Network180 staff members are involved by invitation only. Network180 staff members are available for consultation regarding the administration of the COMPASS and for technical assistance in action plan development/implementation. Network180 does not collect the results of the COMPASS. Network180 convenes a meeting approximately twice a year of all of the Network180 providers. Each provider offers a general description of their experience with the COMPASS and describes progress on the Action Plan. Action Plans are copied for distribution to all of the meeting participants.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indictors? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

In 2006, Network180 created a Process Improvement Team that included Network180 and provider staff that focused on screening for COD. A similar team was created to look at data collection. After a period of time, it was determined that these teams were interconnected and they began to work in collaboration with one another. The result is the Network180 COD Data Collection Project. A mechanism was developed for collecting data on co-occurring disorders that are identified through the screening process. The mechanism involved a change to the network180 authorization system. A drop down box was added to allow the following designations: (0) Neither Disorder (1) Single Disorder (2) Pre COD (4) COD. The data collection process was piloted at our Access Center, and at two providers sites. The mechanism was added to the network180 authorization screen for voluntary system wide use on October 1, 2006, and

was mandated January 1, 2007. This will enable the Network180 and system providers to determine the prevalence of co-occurring disorders.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

As stated previously, participation in the Network180 Date Collection Project became a system requirement on January 1, 2007. There has been discussion regarding practice guidelines for welcoming, assessment, treatment plans, and stage match interventions. A team of provider and Network180 staff has been identified to develop clinical practice guidelines. This work is scheduled to begin in the 2nd quarter.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how IDDT teams promote practice improvement in the system as a whole.**

Network180 has identified three case management agencies to implement IDDT: Touchstone innovare, Hope Network, and Gerontology Network. Each of these agencies was an active participant in the CCISC initiative prior to their involvement in IDDT. Each of the agencies has signed the Consensus Document 2006, and is anticipated to sign the document in 2007. The implementation of IDDT has allowed them to implement a more focused effort that is part of the broader plan to develop co-occurring case ability in their agency.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

Touchstone innovare, Hope Behavioral, and Gerontology Network completed the Fidelity Measure in 2006. Touchstone had a face-to-face consultation with Patrick Boyle in March 2006, and a MiFAST Fidelity Measure in July 2006. Hope Behavioral and Gerontology Network also had consultation with Patrick Boyle. The consultation to Touchstone was funded by DCH, Network180 funded the consultation to the two other agencies. Additional consultation with Patrick Boyle is planned for this year. In collaboration with the IDDT providers, Network180 created the IDDT Evidence Based Practice Quarterly Report (see attached).

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are**

clinical training goals (e.g., assessment, treatment planning, motivational interviews), what policies or procedures are in place to make it likely that clinicians will be organized and expected to being to use the training in their work?

The CCISC curriculum team developed the following training modules for use throughout the Network180 system:

- Welcoming
- Stages of Change
- Introduction to Substance Use Disorders
- Introduction to Mental health Disorders
- Relapse Prevention
- Motivational Interviewing

In 2005, Kathy Sciacca provided a 3 day training for 40 system clinicians and supervisors in the use of Motivational Interviewing. Additionally, 19 of the 40 also received an additional 2 days of training to enable them to train their program staff in Motivational Interviewing. The group developed the 5 two-hour training modules in motivational interviewing highlighted above.

The CCISC Consensus Document 2006 and 2007 offers an incentive for the development and implementation of a training and supervision plan regarding co-occurring disorders. Some providers have used the CODECAT as part of their plan, but it has not been required.

Additionally, all system clinicians who are responsible for requesting authorization from the Network180 system have been trained in the COD Data Collection Project.

Ken Minkoff M.D. and Chris Kline M.D. presented training on the Integrated Longitudinal Strength Based Assessment (ILSA) in December of 2006. This training was open to the CCISC team trainers, as well as additional supervisory/leadership staff.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

We continue to have difficulty with the apparent contradictions in the scope of practice for bachelor's level staff as defined by the following sources:

- Social Work Licensing Regulations
- Public Health Code
- Deficit reduction Act
- ICRC

In statewide discussions, it appears that the CMH/PIHPs have made their own attempts to reconcile the contradictions, but in a manner that is not planned or coordinated as a group. It would be helpful if the state could offer some interpretation or direction that we could all follow, so that we aren't all struggling with the same issue, independent of one another.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

The IDDT providers have identified a need for more expertise in the area of Substance Use Disorders. Network180 received a Federal Block Grant to provide training in SUD treatment, interventions, and supervision to all of the case managers and supervisors in the Network180 system, this would include each of the IDDT providers.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

There is no need for an amendment.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.**

The Network180 EBP IDDT report asks for details of IDDT activity from each of the funded providers. There is an expectation that an action plan will be developed from the IDDT fidelity measures and that action plan will provide service improvement.

17. **What actions are being taken by the PIHP to sustain this initiative after the block grant period?**

The continuation of the CCISC initiative will help to sustain the gains made through the funding of IDDT programs.

1. **Project Title:** Co-occurring Disorders: Integrated Dual Disorders Treatment
Contract Number: 20071294
Project Number: 20712
Time Period: October 1, 2006 – December 31, 2006
MDCH Specialist: Tison Thomas

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The Northwest CMH Affiliation has moved past the initial planning phase into implementation of system-wide transformation work. Our prior work has been a prerequisite for successful development and implementation of the IDDT-COD EBP (evidence based practice) for the adult SPMI and adult SMI with Co-occurring Disorders (COD).

The Improving Practices Leadership Team (IPLT) has continued to serve as a conduit to provide information to the community relative to systems transformation. Our team continues to monitor and facilitate implementation of future evidence based, promising, and emerging practices as part of the bigger picture of systems transformation.

The IPLT held its most recent quarterly meeting on December 12 in Traverse City. In addition to quarterly updates from the three block grant Evidence Based Practices (Co-occurring Disorders, Family Psychoeducation and Parent Management Training) the team received information about Recovery and the Wellness Recovery Action Plan (WRAP) at Northern Lakes CMH and the Peer Delivered Services Program at West Michigan CMHS, Peers in Life: Learning, Aspiring, Recovering and Supporting (PILLARS). The team reviewed and finalized a mission statement, the annual work plan and a schedule for next year. Vision Statement: "The Improving Practices Leadership Team will lead a regional, system-wide systems transformation with improved services through the use of evidence based practices to reach desired outcomes and offer consumer driven choice". The IPLT is scheduled to meet again March 13 in Cadillac.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

The IPLT has continued to meet quarterly although with the modification of our Affiliation PIHP structure now directly reports to the Joint Leadership Team (JLT) and coordinates with other standing PIHP committees. The JLT is supported in its work by the Joint Executive Team (JET) whose members include Greg Paffhouse, NLCMH CEO, Bill Slavin, Chief Managed Care Officer, and Rich VandenHeuvel, West Michigan Community Mental Health Systems CEO) which meets twice monthly. The JLT meets monthly and its members include staff from both Affiliates and who serve to provide direction, leadership and support to PIHP operations. Current JLT members are: Dave Branding, Bruce Bridges, Julie Burke, Lisa Hotovy, Terri Kelty, Chuck Kopinski, Greg

Paffhouse (CEO), Bill Slavin (Chief Managed Care Officer), Emily Smiddy, Rich VandenHeuvel and Becky Vincent. In addition David Riddle, DO (medical director) serves as an ad hoc JLT member and sits on assigned PIHP committees.

The JLT roles and responsibilities include the following:

- Will address the functions of the systems team to ensure they are being met
- Will reinforce the affiliation structure and PIHP focus
- Ensure resources and support are necessary to support PIHP operations (including evidenced based practice implementation)
- Ensure compliance with BBA Standards
- Ensure the affiliation is prepared for site reviews
- Act on recommendations, approve policies and other items, identify priorities and assign responsibilities

Shown below is the current IPLT membership:

Improving Practices Leader	Bill Slavin
Specialist in MI Services	Josh Snyder
Specialist in SED Services	Richard Osburn
Specialist in DD Services	Darryl Goodman
Specialist in SA Services	Dennis Priess
Finance	Lauri Fischer
Data	Chuck Kopinski
Evaluation	Travis Merz
Consumer Employed by PIHP	Nanette Marvin
Family Member of a Child	Jane Sank
Lead for COD	Joe Garrity
Lead for PTMO	Mary Hubbard
Leader for peer-operated services	Ernie Reynolds
Peer Support Specialist	Mary Beth Evans
Family Psychoeducation	Dave Byington
Psychiatrist	Dr. Curt Cummins
Director of QI	David Branding
Clinical Director (WMCMHS)	Emily Smiddy

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

Mailed with this narrative is our Northwest CMH Affiliation and Northern Michigan Substance Abuse Services Regional Charter Agreement adopted June 13, 2006. This document continues to direct our nine county planning efforts and additional geographically based charter agreements will be developed. We have also mailed our:

- FY 06/07 Workplan (revised 1/9/07) to reflect overall system priorities.
- FY 06/07 Timeline

Note: The workplan and several others had been submitted to MDCH earlier this month as part of our COD-IDDT contract amendment request.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

By design we have engaged the above individuals and organizations mostly in our Traverse City site. Our intent is to develop COD-IDDT first here and then to expand to the NLCMH southeast county operations and to West Michigan CMHSP service area. Most work has continued internal to the PIHP/CA service delivery system although work with the broader community is anticipated consistent with our work plan. We have expanded consumer input and information beyond the IPLT through providing communications and having discussions at Regional Consumer Forums and Affiliate specific consumer advisory/advocacy groups.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

An updated COFIT will be completed January 2007. The COMPASS tools will be administered to all sites and offices. NLCMH Northwest will complete its third COMPASS the second Quarter of FY 2006/2007.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality development and progress for participating programs? What plans are there for widening program participation?**

The COMPASS tools will be administered to all sites and offices. NLCMH Northwest will complete its third COMPASS the second Quarter of FY 2006/2007. By 2/28/2007 NLCMH Northwest will have conducted its third COMPASS. WMCMHS completed its first COMPASS in 10/06 and will complete its 2nd in 10/07. Results will be used to assist in refining program goals and objectives. By 3/1/07 NLCMH Southeast will have completed an initial self-assessment using the COMPASS.

8. **How has the system organized quality improvement activities related to monitoring improvement and integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

A Fidelity Review and GOI were conducted internally. Patrick Boyle and members of the MiFast team conducted a Fidelity review in the Traverse City office on August 9th and 10th. The results were reviewed with NLCMH by Patrick Boyle and Elizabeth Kibby. The results are being analyzed. Patrick Boyle has discussed the results and will assist NLCMH in developing a plan to improve service delivery. Part of the corrections will include measures to improve systems change efforts. Included in the current fiscal year Affiliation and NLCMH Quality Improvement Plans have been outcomes related to integrated services delivery. In addition the Director of Quality Improvement (Dave Branding) is a member of the Fidelity Review team.

The NLCMH QI Plan and Outcome Monitoring Grid were revised at the conclusion of the last fiscal year and approved by the NLCMH Board in December. The grid includes four new measures specific to IDDT including: 1) The percent of IDDT recipients in each

stage of change, 2) The percent of IDDT recipients in each stage of treatment, 3) The percent of IDDT recipients in supported employment, and 4) The percent of adults with mental illness and substance abuse receiving IDDT services. These measures will be reported to the QI committee twice annually and the results will be used along with the findings of on-going self-assessments and fidelity reviews to gauge the level of implementation of IDDT as well as to improve the quality of IDDT services being provided.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

NLCMH and the Northwest Michigan CMH Affiliation have been reviewing policies and procedures that address the concept of Welcoming, including Access and Accommodations, No Wrong Door, and Accessibility, based on the CCISC work of Drs' Minkoff and Cline. Joe Garrity has taken the lead on review of existing NLCMH policy, as to COD-IDDT, in coordination with the NLCMH Chief Operating Officers. We are presently revising the NLCMH Assessment and Crisis Assessment forms to include more specific detail as to substance use. The Affiliation CCISC Outcome Fidelity Implementation Tool (COFIT) Leadership Team continues to review progress on the COFIT work plan, particularly in regard to policy changes

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The Co-occurring Disorders (COD) PIHP leadership team (subcommittee of the IPLT), consists of members from the IPLT leadership team has continued to meet approximately monthly and includes members Bill Slavin representing the PIHP, Josh Snyder of West Michigan CMHS, Joe Garrity of NLCMH and Sue Winter representing Northern Michigan Substance Abuse Services (CA). This group has been empowered by the PIHP (affiliation model), the two CMHSPs, and Northern Michigan Substance Abuse Services (CA) to provide direction to our system transformation efforts across the nine counties.

Most recently this group has reviewed the proposal for use of PIHP block grant carry forward funds, which was submitted that afternoon, the training schedule for 2007, and received a report from the access workgroup on the demographic pilot project. The team reviewed updates form the access work team and discussed the need for a process to identify and track common outcomes for persons served under the block grant. The group also discussed common screening and assessment tools and the feasibility of using an automated assessment program, the ASI-MV. They also reviewed the tentative Evidence Based Practice Work Plan for FY06/07 and a list of trainings that are planned for 2007.

We also have continued the COFIT Leadership Team, which recently completed the second annual evaluation of the provider network. Members (representatives of the mental health and substance abuse provider network) used the "Systems Measurement Tool For The Comprehensive Continuous Integrated Systems of Care Model For

Integration of Psychiatric and Substance Disorder Services" (COFIT) scored items in four of six categories: Implementation, Welcoming, Accessible, and Integrated. The final two domains, Continuity and Comprehensiveness will be scored on February 9. Following completion of the assessment comparisons will be made to the previous years' assessment to track progress on work plans and updated work plans will be developed.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

Please see the FY 06 Yearly Report submitted previously for past activity and Question 8 above. The Northwest Michigan CMH Affiliation remains active with the Mighti Group chaired by Jane Konyndyk of Network 180, and is taking part in a SAMHSA COCE Assessment/Screening Pilot project. Linda Dishman and Becky Vincent represent NLMCH on this project. NLMCH has incorporated the DALI-14 M, which is triggered by the CAGE, into its computerized Access Screening form. NLCMH will also pilot the use of the Addiction Severity Index-Multimedia Version 5 (ASI-MV Version5). The local CA Northern Michigan Substance Abuse Services (NMSAS) uses this tool. If adopted, a unified Data Collection system will exist within the NLCMH/NMSAS shared catchment area.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g. assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

Please see the FY 06 Yearly Report submitted previously for past activity and the attached FY 07 workplan and time line. Our plans include the following:

- We plan to continue contracting with Dr. Minkoff and Dr. Cline. They will provide ongoing technical assistance to fully implement the Charter Agreement and assist with systems change. We seek to contract with Dr.'s Minkoff and Cline to provide a "training of trainers". This step is imperative in order to carry the COD–IDDT training to West Michigan CMH as well as continue to provide a measure of fidelity to the model by conducting ongoing trainings. This step is intended to assist the Northwest Michigan PIHP to become self-contained in implementing COD-IDDT. The Northwest Michigan CMH Affiliation will be able to serve as a Center of Excellence to the Northern Michigan areas.

- The Northwest Michigan PIHP will continue to contract with Patrick Boyle of the Ohio SAMI to provide IDDT-COD training to both the NLCMH Northwest and

NLCMH Southeast ACT Teams. Patrick will also assist in the Fidelity and GOI reviews.

- The Northwest Michigan CMH Afflation will have staff trained in Supervisory and Implementation Strategies.

- The Northwest Michigan PIDP will have team leaders visit ongoing COD-IDDT teams in Ohio to review effective programs and treatment strategies.

- The Northwest Michigan CMH Affiliation will provide funding to the Fidelity Review Teams.

- The Northwest Michigan CMH Affiliation will contract with Dr. David Mee-Lee, to provide training on Person Centered Planning with consumers with COD. Additionally, we will contract with Dr. Mee-Lee to provide intensive training to lead workers and supervisors in COD. The supervisory training will assist Northwest Michigan CMH Affiliation, in improving service delivery and ensure Fidelity to the IDDT-COD model.

- The Northwest Michigan PIHP will contract with Heather Flynn PhD to provide advanced motivational interviewing skills to Clinical staff. Dr. Flynn will engage in ongoing supervision using Videotaped sessions. NLCMH has participated in a consortium to bring national speakers on COD to Northern Michigan.

- The Northwest CMH Affiliation will assist in bringing Claudia Black MSW to Northern Michigan. She will present information on Substance Abuse and Depression. This will assist the Northwest Michigan PIHP in facilitating collaboration among Mental Health and Substance Abuse systems.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

As noted in previous submissions staff time is our greatest barrier. This will be helped if our proposed contract amendment to permit carry forward of unspent FY 06 funds is approved. However, this will not alleviate the challenge of skill development across a geographically expansive, diverse, and under-resourced provider network. This is barrier is likely to increase with the ending of the block grant, rumored CMHSP General Fund budget reductions, and a potential loss of Medicaid capitation due to rebasing capitation rates.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

Attitudinal barriers remain but less resistance is being encountered than when the initiative was started. Staff turnover has created some problems. While some policies, in regard to Welcoming and Accessibly of Services have been revised, they still do not reflect a job description that identifies competencies for singly trained clinician's at NLCMH. Another barrier to implementation not anticipated is the competition for the limited number of national

experts/trainers. Both DCH and other PHIP's are competing for the same limited number of trainers. NLCMH and WMCMHS are considering ways to provide training on a regional basis and will consider sharing experts across boundaries. Due to the competition for training time, much of the anticipated training was pushed back which has slowed some development and training.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

While we did not expend all allocated funds in FY 06 we anticipate fully expending currently available FY 07 funds and the funds requested in the January 2007 contract amendment request.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

Please see the attached COD-IDDT – EBP Work Plan revised 1/9/07.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

Presently our focus continues to be on skill development, policy and practice development and/or changes, development of internal training capacities and skills, and our broader efforts to change the overall treatment and support culture across our nine counties.

Report Completed by: Bill Slavin and Greg Paffhouse
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Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

1. Report Period	**Period Ending December 31, 2006 – Report Due Date January 31, 2007 – First Quarter Report FY 2007**
PIHP	**Saginaw County Community Mental Health Authority**
Program Title	**Improving Practices Infrastructure Development Block Grant – Co-Occurring Disorder: Integrated Dual Disorders Treatment**
Executive Director	**Sandra M. Lindsey, CEO**
Address	**500 Hancock Street, Saginaw, MI 48602-4292**
MDCH Specialist	**Tison Thomas & Patricia Degnan**
PCA#	**20715**
Contract#	**20071291**
Federal ID	**38-3192817**

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team. Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The CEO of SCCMHA appointed the chairperson of the Improving Practices Team as well as team members during the summer of 2005. The 20 member Improving Practices Team met 6 times during FY 2006, in October, November, January, March, May and September. The IPLT now meets on a quarterly basis; the team met in October 2006 and was scheduled to meet in December but that meeting was cancelled due to both illness and weather. Communications from SCCMHA to the team also occur via e mail throughout the year. At SCCMHA, the Improving Practices Leadership Team was developed with the role of oversight for all evidence-based practices and related improvements, including promotion of a recovery philosophy throughout the SCCMHA system. The SCCMHA Improving Practices Team has been conducting reviews of current service practice areas, including Assertive Community Treatment, Supported Employment, and Dialectical Behavior Therapy against fidelity requirements for those specific evidence-based practice areas. This team also has the responsibility to provide guidance to the network and SCCMHA management and administration in the implementation of new evidence-based practices, including the focus of the COD/IDDT model initiated in FY 2006 as well as the FY 2007 initiated Family Psychoeducation (FPE) and two EBP related training grants/projects of SCCMHA – COD/IDDT enhancement and Recovery. A member of the Improving Practices Team serves on the state Recovery Council

and another member serves on the trained, Michigan MI-FAST team. We had had excellent substance abuse provider representation in our process, including from the local Substance Abuse Coordinating Agency. The IPLT oversees all COD/IDDT implementation efforts; COD/IDDT practice began in the SCCMHA adult case management programs October 1, 2006. Evidence-based practice incorporation into the SCCMHA Continuing Education Program also began with FY 2007.

Integrated services as well as all EBP efforts have been included in the 2006-2007SCCMHA strategic plan development. In addition to direct consumer participation in both the Improving Practices Leadership Team and the COD/IDDT workgroup, the two consumer leadership teams of SCCMHA receive reports on the progress SCCMHA is making towards implementation of integrated service delivery, and were involved in the decision-making for all improving practices goals for FY 2007.

The activities of the COD work group and the Improving Practices Leadership Team are routinely reported to the SCCMHA Quality Team. SCCMHA incorporated EBP and COD/IDDT policies into the provider network policy manual during FY 06 as well, and any revisions as needed for FY 2007 will be made in these meeting venues.

The COD/IDDT workgroup met monthly in FY 2006, and is moved to bi-monthly meetings in FY 2007. The FPE group began meeting in October and is meeting monthly during FY 2007 to begin implementation.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHIP and CA system, and how is it empowered by system leadership?**

SCCMHA is a single PIHP/CMHSP with a single CA; CA representation on the SCCMHA IPLT includes a member from the CA office staff, as well as representatives from several key CA agencies/programs, along with other representatives from mental health provider programs serving adults with serious mental illness. Leadership team membership has remained fairly stable since inception in fall 2005, with some changes in consumer representation and some additional CA and mental health staff members. The IPLT is empowered by the SCCMHA administration, through the management, leadership and quality teams to oversee implementation and review progress in all evidence-based practice areas, including but not limited to COD/IDDT. The IPLT reports officially to the SCCMHA Quality Team. Members of the IPLT also include the Director of

Network Services & Public Policy, who is also administratively responsible for implementation of evidence-based practices within the SCCMHA system; the Director of Clinical Services & Programs; and the key adult case management program supervisors/directors, who are implementing compliance with dual diagnosis enhanced programs. Other team members include consumers, contractors, the Continuing Education Supervisor and various representatives from DDE and DDC identified programs. The CEO is a member of the management, leadership and quality teams where EBP updates are provided. Both the SCCMHA CEO as well as the Medical Director have attended COD/IDDT training. The Director of Network Services & Public Policy is also the contract manager for the SCCMHA/CA agreement. IPLT membership roster has been submitted previously, including updates. Overall EBP clinical oversight and coordination is also provided by the SCCMHA Service Management Team which consists of the SCCMHA CEO, Director of Network Services & Public Policy, Director of Clinical Services & Programs, and Director of Care Management & Quality Systems.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e. g., welcoming, screening, data collection, etc.)**

   Yes, SCCMHA has developed a consensus document; this has been previously submitted to MDCH. This document was reviewed and endorsed by both the COD/IDDT workgroup as well as the IPLT, and has been sanctioned by the SCCMHA Board of Directors, the SCCMHA CAC and the CA Advisory Board as well as local judges. Parties to the document include key service provider/programs and CA leadership. SCCMHA developed EBP and COD/IDDT policies in FY 2006; a welcoming policy may still be developed. In addition, as previously submitted to MDCH a detailed work plan is reviewed by both the IPLT and the COD/IDDT work group regarding COD/IDDT implementation. Recovery has also been a topic of discussion and is part of the work plan and policy development. During this quarter training on the COD/IDDT practice model was provided specifically for the crisis residential program. System priorities for FY 2007 include provision of COD/IDDT services beginning October 1, 2006 and external fidelity review during this fiscal year as well.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of the PIHP/CA system. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

   Consumer input is routinely included as consumers and families are members of EBP related teams: IPLT, and the COD/IDDT and FPE committees. Periodic

EBP updates are provided to the SCCMHA Citizens Advisory Committee as well as the two consumer leadership teams at SCCMHA. The latter has reviewed and commented on content for EBP related brochures is be issued soon by SCCMHA. SCCMHA issued a children's guide related to EBP in September 2006, and has initiated planning for local system planning related to children's services, including the court system and the Department of Human Services.

Other participation and involvement of parties not directly part of the local PIHP/CA system will need to be determined yet this year.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process. If not, what plans are there to use the tool?**

   The COD/IDDT committee completed the CO-FIT over the course of three meetings in FY 2006; we found the tool a bit ambiguous and open to interpretation in some areas, and also only had 'soft' data upon which to base some of our scoring. The preliminary score, which we consider a baseline score for the SCCMHA system, was 219. There are no current plans to re-score using the CO-FIT at this time, however some of the areas created discussion and a higher level of awareness within the COD/IDDT team membership, and key themes from that discussion are being incorporated into the work plan in FY 2007.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of the action plan development and progress for participating programs? What plans are there for widening program participation?**

   All of the four adult case management programs are expected to use the COMPASS as soon as feasible this fiscal year. Those results will be reported to the COD/IDDT committee and the IPLT. The SCCMHA ACT team has used the COMPASS in the past. All of these five programs have been identified as DDE programs by SCCMHA and will be reporting on their overall implementation progress to the COD/IDDT committee this year. The remaining SCCMHA and CA providers are considered DDC programs, and are expected to implement some aspects of the fidelity scale for COD/IDDT, including staff orientation and training.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and the indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

As mentioned earlier, COD implementation progress is reported through the SCCMHA quality process. Indicators that SCCMHA intends to use to measure progress include elements of the COD/IDDT fidelity scale as well as overall outcome measures of consumer quality of life and satisfaction. One basic indicator SCCMHA will use is the level of dual diagnosis penetration rate in the SCCMHA information system.

9. **What policies and procedures have been articulated or are in the process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

   As mentioned previously, a general EBP policy and a specific COD as well as FPE policy have been developed, applicable to all service providers. The COD policy includes a summary across all provider types of COD/IDDT expectations. The Encompass IS screening and assessment tools for integrated service planning and delivery have been implemented by all programs effective FY 2007. Uniform reporting has not yet been implemented as SCCMHA has been advised by MDCH to not report services until post the external fidelity review by the MI-FAST team during FY 2007.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit into the larger system's movement towards integrated treatment, and how are they supported by their agencies in this process? Describe how the IDDT teams promote practice improvements in the system as a whole.**

    As mentioned earlier there are five teams implementing COD/IDDT as DDE programs this year. These are all of the adult case management programs of the SCCMHA system, and the SCCMHA ACT team. This decision was made by the COD/IDDT group and endorsed by IPLT and SCCMHA administration. All of the agencies represented by these teams – two contract agencies (Training & Treatment Innovations and Saginaw Psychological Services) and two direct operated programs of SCCMHA (Community Support Services) – have supported numerous staff members attendance at meetings and training sessions to support implementation of the COD/IDDT practice during FY 2006 and again to date in FY 2007, including assuming the costs of trainings and travel. The team supervisors are represented also as members of the COD/IDDT committee as well as the IPLT; one supervisor is the COD/IDDT committee facilitator.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MI-FAST) fidelity reviews? What**

other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?

SCCMHA has incorporated the fidelity scale into policy as well as DDE and DDC program identification and expectations for all members of the SCCMHA network. SCCMHA requested a March or April 2007 external fidelity review by the MI-FAST team and has not yet heard confirmation of scheduling; some pre-fidelity review will take place prior to that date as the teams are implementing service delivery this year. One of the SCCMHA COD/IDDT and IPLT members is a member of the Dr. Boyle trained state MI-FAST team. During FY 2006, SCCMHA participated in all external consultant trainings and resources made available, including numerous Dr. Boyle, Dr. Mee Lee, Dr. Minkoff and Dr. Cline sessions. Dr. Minkoff will return for an in-person consultation day at SCCMHA March 22 for this purpose.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinical scopes of practice and core competencies been drafted are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g. assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

SCCMHA administrators and adult case management program team supervisors have communicated to their teams these expectations during FY 2006. SCCMHA has also made every effort to communicate to staff and providers through newsletters, leadership and provider meetings, and policy dissemination the expectations for clinicians. The CODECAT has been used by several provider programs to date. It is expected that the DDE programs will use and report on their CODECAT status to the COD/IDDT committee this year. The SCCMHA policies indicate clinician work expectations and SCCMHA job descriptions are also being updated for this purpose. SCCMHA has incorporated COD/IDDT training into the system continuing education plan; all training opportunities are communicated to clinical program staff members. The SCCMHA Training Supervisor developed training protocols for basis COD/IDDT training this past quarter. Both DDE and DDC programs have identified staff expectations. Supervisors are reporting their status at routine COD/IDDT and staff meetings this year.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

One issue for SCCMHA has been numerous MDCH venues impacting the one practice of COD/IDDT; the policy academy as well as four active committees or subcommittees have been challenging for SCCMHA to attend at every venue given limited resources. While the information has been helpful, the various venues also have created some confusion on accurate information. SCCMHA would suggest that MDCH consider streamlining, especially in recognition of multiple EBP implementation at PIHP sites. MDCH could also make available the quarterly reports of PIHPs for any EBP to all other PIHPs to assist with learning and sharing of information in a time efficient manner.

Another administrative barrier has been the state's inability to yet implement a statewide consumer outcome tool for adults with mental illness. SCCMHA may implement a local systemwide tool regardless this year in order to collect consumer specific outcomes relative to all EBP implementation efforts.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

Administrative barriers for SCCMHA are primarily limited time and resource related. Some SCCMHA leadership members were able to attend the December Ohio COCE leaders training in December 2006. We have arranged additional Dr. Minkoff training and consultation for SCCMHA for March through MDCH. General guidance to PIHPs from MDCH on the implementation of multiple EBPs would likely be helpful to SCCMHA teams as well as other PIHPs involved in system transformation efforts. DDE and DDC teams will be asked to report on all clinical barriers through the COD/IDDT meetings in order that they may be addressed consistently and promptly.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

SCCMHA requested an amendment regarding MI-FAST related costs and is awaiting confirmation from MDCH regarding this request. Allocated resources of the project are projected to be used by SCCMHA at this time as budgeted.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support maximum amount of leverage for practice improvement?

SCCMHA will be monitoring DDE programs' progress and DDC programs' status in the coming quarter. Dr. Minkoff will be at SCCMHA March 22 for a consultation visit. Fidelity and pre-fidelity reviews are planned. Continued project funds use to support EBP and evaluation contractor time and supports for implementation are expected.

17. What actions are being taken by the PIHIP to sustain this initiative after the block grant period ends?

SCCMHA has already incorporated the practice expectations into policy and staff and provider continuing education programs. SCCMHA has initiated an adult case management supervisors venue, and it is likely that this forum will provide the ability to review progress, along with periodic SCCMHA fidelity reviews of DDE programs over the long term for sustainability purposes.

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COD - Initiative
Quarterly Narrative Report
1st Quarter / FY 2007 October 1, 2006 - December 31, 2006

1. COD Initiative
PCA #06-20716
Contract: #20071342
1st Quarter / FY 2007 October 1, 2006 through December 31, 2006
Karen Cashen

2. The Thumb Alliance PIHP's Improving Practices Leadership Council (IPLC) continues to provide system level oversight to the IDDT tool kit implementation process. As regional action planning in response to the IDDT baseline fidelity assessment progresses, the IPLC anticipates the need to address region wide barriers to increased model adherence and will act as a conduit to the Thumb Alliance

In addition, the IPLC has begun to oversee additional key clinical practices. The Thumb Alliance has now formally endorsed the creation of a regional Recovery Workgroup to provide direction to the system as we move towards the creation of a true Recovery focused environment. The Lapeer CMHSP has also begun to undertake implementation of the Family Psych-Education Tool Kit, and is reporting on the progress of that endeavor to the IPLC.

3. The Thumb Alliance PIHP is working towards formal integration of the public mental health and substance use systems concurrent to the efforts to implement the IDDT tool kit. Both the PIHP Board, and the governing St. Clair County CMH Board have endorsed the movement of St. Clair County CMH towards formal designation as the regional Coordinating Agency. The necessary formal waiver requests and request for designation as the regional CA have been approved by both boards and will be submitted soon. The Thumb Alliance PIHP anticipates receiving designation as the regional CA effective 10/1/07. The Thumb Alliance Management Council has taken leadership in the CA transition activities, with all three CMHSP Directors (who are standing members of the Management Council) taking lead with their local county Board of Commissioners to ensure appropriate education and to request endorsement. The Management Council has formed, via the PIHP a CA Transition Workgroup to implement the transition plan. The Chief Operating Officer (COO) of the PIHP chairs that group, which also consists of the current CA Director, the PIHP Chief Clinical Officer (CCO), and key administrative leadership staff in the areas of IS, QI, Data Management, Fiscal, and Contract Management.

There is significant crossover between that group and the two primary groups related to the implementation of the IDDT Tool Kit (the IPLC and its sub work group, the Co-Occurring Disorders Workgroup). The IPLC is chaired by the PIHP Medical Director. The COO and CCO of the PIHP are members of both the IPLC and the COD Workgroup, as is the CA Director and the QI/Data

Management Director from the PIHP. Clinical Leadership representatives from the three Thumb Alliance CSSNs are also members of both the IPLC and the COD Workgroup. All of these groups report to the Thumb Alliance PIHP Management Council.

4. The Thumb Alliance PIHP has developed and previously submitted two documents related to system transformation. The Thumb Alliance revised its Vision statement in the last fiscal year to better capture its goals and efforts towards system transformation. In addition, the Management Council and the applicable Boards endorsed a Charter document created by the IPLC to guide its efforts in the system transformation process.

   The Thumb Alliance PIHP has not as yet created formal consensus agreement documents with the provider network system.

   Welcoming and Integrated Screening are two topics that are currently being addressed by the PIHP within the IPLC construct. The PIHP is in the process of revising its system wide policy on access to ensure it is appropriate to all populations we serve. Among the changes being made is the incorporation of the concept of welcoming throughout the process. We are also currently working with Wayne State University and participating with the COCE project to explore the concept of integrated and standardized screening throughout the Thumb Alliance region.

5. Much of the energy over this past quarter was directed at the completion of the baseline IDDT/GOI fidelity assessment process and the development of local action planning teams to respond to the results of those assessments. We have not had high level involvement of those systems external to the PIHP/CA system throughout this quarter. Higher level involvement is anticipated as we begin to flesh out action plans and continue down the road to formal system integration, however.

6. The Thumb Alliance PIHP did complete the CO-FIT 100 last fiscal year. We administered the CO-FIT 100 to a group that included our Management Council as well as our IPLC. As a region, we scored 154/500 on the CO-FIT 100. As we analyzed the results of that process, we struggled to be able to use the results for the development of a work plan with any specific tasks. The tool and resulting data was too global and general, in our opinion. As we consulted with Wayne State University regarding our results and next steps, we made the decision to move ahead with the IDDT/GOI baseline evaluations and to table use of the CO-FIT 100 for future discussion should the IDDT/GOI process not yield positive outcomes for the system.

7. We have not implemented the COMPASS to date. We are focusing on the IDDT/GOI fidelity assessment process at this time.

8. The Thumb Alliance PIHP has begun to organize QI activities related to this initiative. Under the leadership of our QI/Data Management Division, we have shown significant improvements in our conscientious reporting of demographic data describing the prevalence of COD within the public mental health SMI population. We have also begun work revising policies to reflect necessary system attention to co-occurring disorders, including our access policy and our credentialing and privileging policy. We have formed a sub-group to evaluate our screening protocol and process (both at the front door and within the treatment continuum) and will examine the potential benefits of using standardized integrated tools throughout the system.

   The Thumb Alliance PIHP has also developed an aggressive training protocol related to system competency to treat individuals with COD. We are working with Wayne State University to provide training in the areas of:

   - Understanding IDDT;
   - Motivational Interviewing – including formal training, coaching, and scoring of taped sessions;
   - Stage-Wise Intervention;
   - Pharmacology and COD for medical and non-medical providers;
   - Understanding Addiction;
   - Screening, Assessment, Diagnosis, of SUD in the SMI Population; and,
   - Clinical Treatment of SUD for individuals with SMI.

   The Thumb Alliance is working with WSU to make available CEUs and CMEs for as many courses as possible in this curriculum.

9. The Thumb Alliance PIHP is in the process of revising its policies on Access and Credentialing and Privileging. We anticipate more significant policy development and revision to needs to be articulated via the local action planning processes that are now being initiated in response to our baseline IDDT/GOI fidelity assessment process. The process we use for these initiatives will likely vary based upon the type of policy that requires either revision or development. All recommendations and actions in this area will come via the regional COD workgroup.

10. We have just begun this process with the wrap up of our baseline IDDT/GOI fidelity assessment. Each CSSN was asked to form an IDDT implementation team with representation from the direct service providers (including peer support staff), key agency decision makers, agency QI staff, and program leadership staff. These groups are now being formed in Sanilac, Lapeer, and St. Clair Counties. They will take lead in developing and implementing local action strategies regarding IDDT implementation and will forward recommendations to the regional COD workgroup regarding potential IDDT enabling activity at the regional/PIHP level.

11. See above in regards to activities underway. Our baseline IDDT/GOI fidelity assessment was completed in the first quarter of this fiscal year. We have been

contracting with WSU from the outset on this process. The Thumb Alliance PIHP opted to create its own team and contract with WSU for leadership and consultation. Our team was co-lead by an experienced WSU evaluator and our clinical analyst, a PhD. Psychologist who has received training in this process via Patrick Boyle (training and shadowing) and WSU. Our team included primarily PIHP staff. One unique quality of our evaluation team relative to MI-FAST and other evaluation teams we have seen/heard about, is that the Thumb Alliance PIHP elected, from the onset, to include a peer support staff as a full member of the evaluation team. We believe this has allowed us to look at our regional programs and policies with a more complete perspective and has definitely added value to the process.

The Thumb Alliance has been represented at training and consultation provided by Patrick Boyle, as well as the Minkoff/Cline trainings. In addition, we have had a staff member shadow one of Patrick Boyle's review teams in Ohio, we have contracted separately for IDDT/GOI training from WSU, and we have participated with MI-FAST (except for the fact that we are not actually receiving or providing evaluation services via that group).

12. We have not used the CODECAT system wide to date. As we referenced earlier, however, we have initiated an aggressive training protocol this fiscal year that targets a wide variety of staff. Among the objectives of this protocol are to increase the system level awareness of our transformation efforts related to IDDT, to increase the understanding of the IDDT tool kit, and to increase staff knowledge and competency in the identification and treatment of co-occurring disorders.

    In addition, the IPLC has, within its current QI plan, identified review and revision of the PIHP clinical protocols as a current targeted task.

13. The Thumb Alliance has not identified any new barriers this quarter. The barriers identified previously still seem to exist, however, including but not limited to:
    - Lack of integration between the Mental Health and SUD bureaus of MDCH, which seems to cause an inability to make decisions/policy calls that may impact both the MH and SUD systems expediently at the state level;
    - Differences in policies/rules/practices related to confidentiality, recipient rights, ability to pay, etc.;
    - The use of language in licensing rules that causes provider level confusion regarding licensed integrated treatment and the IDDT tool kit implementation; and,
    - The lack of a service code modifier that could be used to more readily track services provided to individuals within a program implementing the IDDT tool kit (to more easily tie programming and fidelity levels to specific consumer outcomes).

14. The Thumb Alliance has not encountered any new barriers over this first quarter. We anticipate that the ongoing development of local action plans will bring local and regional implementation barriers to the surface.

15. We have submitted an amendment with a request to carry forward funds from year one. This need was primarily caused by the baseline fidelity assessment process needing to be continued into the beginning of this fiscal year and our agreement to reimburse WSU for their assistance with this process at the point of completion.

16. The primary activities for this coming quarter are in the areas of local action plan development, policy revision and development (including exploration of the use of standardized integrated screening tools), staff training and curriculum development (in consultation with WSU), and continued participation with state level efforts related to system transformation. The Thumb Alliance PIHP CCO is involved in all of these efforts and we will continue to access WSU for consultation and assistance in the implementation process.

17. The Thumb Alliance created the IPLC with the intent of continuing system transformation efforts beyond the terms of the block grant. It is a group and function that has become embedded within the PIHP structure. In addition, the PIHP is working towards creating training modules based upon the curriculum developed with WSU that will be used as refresher material for existing staff and as orientation/training material for future new staff. The training modules will be placed in our online library and will be updated as necessary.

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